

DOCUMENT RESUME

ED 209 627

CG 015 585

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 TITLE Relationship Group Therapy: A Short Term Approach with Children.
 PUB DATE Aug 81
 NOTE 42p.; Paper presented at the Annual Convention of the American Psychological Association (89th, Los Angeles, CA, August 24-26, 1981).

EDPS PRICE MF01/PC02 Plus Postage.
 DESCRIPTORS *Children; *Counseling Techniques; Counseling Theories; Counselor Characteristics; *Counselor Client Relationship; *Group Dynamics; *Group Therapy; Interpersonal Competence; Play Therapy; Program Descriptions; *Self Actualization; Therapeutic Environment; Values

IDENTIFIERS *Relationship Psychotherapy

ABSTRACT

A new short-term (14-16 sessions) group therapy approach for children, Relationship Group Therapy (RGT), is described. The major group therapy approaches are critiqued and the integration of certain assumptions from each approach are discussed. Stages of RGT therapy and the specific interventions required during various stages of therapy are detailed, as well as qualities of RGT therapists, values inherent in RGT, and the need to evaluate the interventions. Results of a RGT evaluation in an elementary school setting are provided, indicating that the treatment group attained significantly higher goal attainment scores than the control group. Additionally, the appendix contains a sample evaluation checklist for therapists. (Author/JAC)

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"RELATIONSHIP GROUP THERAPY: A Short Term Approach With Children"

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RELATIONSHIP GROUP THERAPY

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Relationship Group Therapy

I: Foundations

A. Critique of the Major Child Group Therapies

Slavson (1943) developed a form of group therapy with children he labeled activity-group therapy. He assumes the basic concepts of dynamics and pathology developed by Freud. In doing so, he assumes the instinctual drives of human beings to be sexual and aggressive and that all forms of growth and development are the direct result of instinctual drives in conflict with the realities of life. He accepts Freud's hypothesis of the nature of the human mind as the "dynamic relations of the id, ego, and superego" (Slavson, 1950, p. 18), and employs the dynamic elements of process suggested by Freud which include transference, free association, insight, sublimation, and the notion of defense mechanisms. Slavson hypothesizes that the children he sees in treatment have had to repress rather than express a significant amount of their instinctual drives and these repressed drives form the content of the unconscious. According to Freudian theory, these drives are no longer in awareness but continue to be the main motivators for our behaviors and feelings. Because of the social taboo toward possessing these drives, defenses are established to prevent them from

appearing in consciousness. Because so much libidinal energy is used for these defenses, the child has too little energy to meet the demands placed upon him or her by the realities of life; and psychopathology, an inability to deal with these realities, develops.

From the Freudian framework, Slavson suggests that a special therapeutic setting is needed that will allow the repressed unconscious material to be expressed. In this way, less energy must be used for defensive purposes and more energy for a positive realistic adaptation.

Slavson attempts to create such a setting. Groups consisting of usually five to eight children, ranging in age from eight to twelve years, meet for two hours a week for a period of approximately two years. They meet in a good sized room, optimally 450 square feet, which is filled with various kinds of toys and games. One adult is present who serves as the therapist. He or she attempts to be, and is trained to be, a passive participant who attempts to be strong, tolerant, calm, and caring. The environment theoretically imposes only the most minimal limits on the children, the prevention of physical injury to self and others. All other behaviors are usually allowed. In such a setting where few restrictions are imposed, it is theorized that children regress; that is, in response to an almost limitless situation, they revert back to an earlier period in their lives where they did not defend against instinctual drives they presently do defend against. Rather, they now express them in the group therapy situation where it is not taboo to

express them. A discharging of repressed feelings and ideations during such a regressed state is called catharsis; and it is one of three processes which Slavson describes as curative factors in activity group therapy.

Catharsis thus decreases unconscious repressed material freeing energy to be used for other areas of one's life. The "permission" to engage in such activities, and the satisfaction from such a form of activity, is central to the child's symbolization of the therapist as the ideal parent. Thus a strong identification is formed. Identification is Slavson's second major curative factor and identification is the child's incorporation of attitudes and values of another, in this case, the therapist, into the structure of his or her own psyche.

Transference, the child's feelings and thoughts toward his or her parents or significant others directed toward the therapist, is a phenomenon that, along with identification, forms the bulk of the relationship from child to therapist. As a child in treatment begins to both cathart in the therapy sessions, and identify with the therapist, the therapist will begin to reflect back to the child the feeling that the child is expressing. This occurs during cathartic play or in the child's interactions with the therapist, which is viewed as a way of helping the child to gain insight into his or her own behavior. Such insight is said to strengthen the ego by helping the child make unconscious material conscious, thus bringing it under ego control. Insight is the third major curative factor theorized by Slavson.

Activity group therapy has significant limitations in theory and in its conduct; and Slavson is the first to point out one of them. This form of treatment cannot be used with aggressive or acting out children. Such children "disrupt the therapeutic atmosphere and group balance by their aggressive behavior which can only be checked through authoritative handling. This would be very undesirable as it would change the children's concept of the group therapist as a warm, accepting, and non-punitive person" (Slavson, 1943, p. 117). Another limitation is the long duration of therapy, usually one to two years. The advancing segments of clinical psychology are stressing the social responsibility of mental health professionals and suggest that new treatments can be devised that will cut down on the duration of treatment so that professionals can utilize their skills with greater numbers of people. While there are no doubt advantages to the long term approach, there is certainly a growing, substantial demand for the development of effective short-term approaches.

Identification as a curative factor brings forth an important question. "Whose values, attitudes and beliefs will the therapist espouse?" Is it his or her own? The western world's, as defined by the therapist? His or her own cultural group or the cultural group of the therapy group's participants? This is never specified and made clear.

Another limitation over the years is that there has been little evaluation of this treatment approach and no evidence that these theoretical formulations, followed by interventions, actually reduces psychopathology. The need

for accountability, now a prominent issue and value in many professional areas, needs to be applied to therapeutic interventions as well.

Lastly, psychoanalytic theory is a model based on internal conflict and conflict between a person and his or her own world. It is a negative model in this sense and colors our view of human beings accordingly.

Redl (1951, 1952) also uses psychoanalytic theory as his framework for working with children primarily in therapeutic camp situations. However, Redl worked specifically with aggressive children and the methods used were markedly different although the basic theoretical framework, psychoanalytic theory, is the same as Slavson. Group and interactive processes are central to Redl's conceptualizations of effective treatment interventions; and the therapist's understanding of these processes is necessary to intervene appropriately. Understanding the "group emotion," the instinctual drives and emotional events taking place within persons under the pressure of the group, is an important formulation. Another important concept is the "central person," often not the leader, around whom most group processes take place. What role a given child has in the group is another important consideration for intervention, as is "contagion," which is basically a conceptualization of influence of peers, in terms of ones stated attitudes, values, beliefs, as well as ones behavior. A group's codes and deviation tolerances, tastes and aversions, and sub-group

formations are other major categories from which a therapist plans an appropriate intervention.

There is primarily one theorized curative factor in this approach, the "regulation of behavioral and social traffic." This involves two major forms of intervention. One is individually oriented and involves the therapist helping children to behave in a different manner, that will achieve results beneficial to that individual as perceived by the therapist and hopefully by the child as well. This may mean, for example, to help a child tell another child, how angry he or she is, using words rather than embarking on a physical attack. The second aspect involves the group and the therapist telling the children what the realities of a given situation are. This may also involve, pointing out to the group the difficulties of a given task, the implications of a given action, the values implied by a certain decision. All of the many kinds of interventions Redl conceptualizes fall under this general heading of regulation of behavioral and social traffic. Through camp activities, much tension reduction occurs which allows children to be more susceptible to these approaches. Redl's goals, however, were not necessarily to work with deeply embedded fixations. He sees his work geared more toward the learning of adaptive skills to be able to communicate more with others, thus increasing children's satisfactions and goals attained, which ultimately would theoretically strengthen the ego.

One aspect that is extremely intriguing about Redl's approach is that while the approach is viewed in psychoanalytic

terms, the interventions appear to be behavioral and can easily be translated into a behavioral approach. Rose (1972) has written his conceptualization of group work, regulating individual person and group contingencies, couching interventions in behavioral terms. Viewing problems that children are experiencing as due to past learning experiences, Rose attempts to manipulate reinforcement contingencies in a therapy group, in an attempt to alter children's behavior. Getting rid of the "symptom" behavior of the child, and reinforcing in its stead a more positive, socially adaptable behavior is the primary intervention and curative factor. It is thought in this approach that behavior change will alter feeling states, rather than feeling states altering behavior, usually the common psychoanalytic formulation. Redl, in his curative interventions, seems to be working under this behavioral assumption. This is probably primarily due to the fact that his treatment is usually short term, not working with "deeply embedded" material. Also, his patient population were more actors, action oriented, than passive and withdrawn youngsters such as would probably be seen in a Slavson type group. Redl's theories concerning groups also lend themselves primarily to an interactive person/person, person/environment interaction, rather than an individual orientation, the latter more psychoanalytic. In Redl's writings, the bridge between his theories on groups and psychoanalytic theory is never made clear.

A limitation of the Redl approach lies in his heavy emphasis on group formation. During camp situations, there

is a great deal of time to allow groups to form, but having children in camp for therapy or together more than 1-2 hours per week is often not feasible. His techniques as well are designed specifically for aggressive children, and this is a limitation. As with Slavson, Redl has never experimentally evaluated his treatment approach and there is no scientific evidence suggesting its positive applicability or feasibility as a treatment modality for a wider range of childhood problems.

Relationship Group Therapy uses a combination of the methods of the Slavson and Redl approach, in a specified way. The theory has been formulated over the past four years while working with children in a school system, counseling center, and in day camp situations. It is considerably based on the professional work of Robert W. Freeman with children in groups. Our curative factors are hypothesized as insight, identification, and the regulation of behavioral and social traffic. While our methods are often the same as the above two approaches, our theoretical formulations are different. Our theoretical approach is based largely on the work of Carl Rogers (1951). His theory is based on an underlying assumption that human beings have, within themselves, a growth potential or a drive for actualization to develop and to solve their own problems when given an opportunity to experience growth. Relationship Group Therapy therapists attempt to devise such a setting and then allow the children to benefit from both insight, feeling oriented or intrapsychic methods, as well as by behavioral and group approaches.

Our theoretical underpinnings allows us to conceptualize ourselves as helping children in allowing themselves to grow and actualize. In Rogerian theory, this is an innate drive and a positive one rather than a negative perspective (drives vs. society). As is often the case, however, from very varying theoretical formulations there often follow very similar interventions, but with distinct differences as well.

There are important differences and advances purported in Relationship Group Therapy as compared with the other models reviewed. The wider approach incorporating two major theories and methods in the child group area increases tremendously Relationship Group Therapy therapists flexibility to intervene in a variety of ways-individually, via group, directly, or indirectly. Slavson's group therapists traditionally intervene primarily in indirect ways toward an individual. Redl's group therapists traditionally intervene primarily in direct ways toward a group. The bringing together of these two main types of interventions allows Relationship Group Therapy therapists the opportunity to work with both passive and aggressive children effectively while allowing for a wider range of possible interventions for a given situation.

Moreover, intervening along two primary categories of functioning, the individual and interpersonal, it is theorized that the impact from this combination will cause a stronger therapeutic effect, i.e. cause positive change to occur more quickly and have this change be more solid and permanent. Thus, Relationship Group Therapy is a short term

approach, usually ten to fourteen sessions. It is felt that the intervention is so dynamic and encompassing, that children actually continue to use the methods and knowledge obtained even more after they leave treatment.

In Relationship Group Therapy, two therapists are present, one male and one female, forming a sub-system, a therapist support system, as well as an effective parenting model. This is unlike the Slavson and Redl approaches, where only one therapist is usually present. The male and female therapists also can offer their particular masculine or feminine perspectives to the group. This also affords therapists the opportunity to work with children who have particular difficulties with male or female adults. Having two therapists also allows for the therapists to intervene more often and more quickly, again intensifying the experience of Relationship Group Therapy groups.

Relationship Group Therapy theory, unlike the other two approaches, contains hypothesized stages of therapy designed in such a way as to promote an effective short term group therapy experience. The therapy, moreover, can be done in a variety of settings and does not need extensive recreational facilities or a wide variety and numbers of toys.

As noted previously, the Rogerian emphasis versus the Freudian emphasis allows a positive mood to prevail. The children are not "sick", but need to develop new skills and methods of interaction through relationships. It entails an approach of exploring and experiencing on the parts of the children, so that their "good" natures will rise. This

is in contrast to the drives versus society approach, the "no win" hypothetical structures in psychoanalytic theory, where we must control our negative biological impulses.

The processes by which curative factors are in operation differ for the three groups. These processes, may be, in fact, the primary curative factor. With Slavson, of course, this process is activity or play, through which catharsis, identification, insight through transference are seen and worked with. The play is again primarily of an individual nature and concerns the child in interaction with objects. For the Redl approach, the group is the primary process by which the regulation of behavioral and social traffic, Redl's curative factor, is carried through. For Relationship Group Therapy groups, this basic process is, of course, the relationship, where identification, regulation, and insight (through many experiences, not just the transference one) are seen. Without play, the group, or the relationship, respectively, each of the approaches would fall apart. It is felt that the relationship is primary because it entails involvement with others which is essential for change. Someone in play or in a group but uninvolved, with no relationships, will not benefit from treatment regardless of intervention.

The discussion of Relationship Group Therapy groups to follow will include sections on curative factors and procedures, stages and methods, therapists, values, and evaluation. These theoretical formulations are based on clinical experiences with children in groups, and have evolved over time. The values section concerns the values that therapists hope children will identify with, coming from the therapists, in

group treatment. This has never been explored in either of the other two approaches. Lastly, Relationship Group Therapy groups have as a critical component the evaluation of the approach; again, something that has not been adequately attended to previously by practitioners of the Slavson and Redl approaches.

B. From Curative Factors to Procedures

Slavson has described his theorized curative factors to be catharsis, identification, and insight (through transference). Redl describes his theorized curative factors as interventions under the general heading of the regulation of behavioral and social traffic. Relationship Group Therapy has as its hypothesized curative factors insight, identification and the regulation of behavioral and social traffic. Insight in Relationship Group Therapy groups also has a broader meaning than when the term is used by Slavson. While insight through the transference relationship is an important dimension of insight, acquisition of insight can also be gained through other processes such as success experiences, feedback, support, and education from the therapists.

Relationship Group Therapy, like activity group therapy, attempts to establish a therapeutic atmosphere which is understanding, permissive, and caring. Such an atmosphere, it is theorized, provides the proper framework for curative processes to take place. Toward this end, an activity group therapist attempts to be warm, tolerant, permissive and caring. The therapist tries to give what can be called unconditional positive regard (Rogers, 1951).

A second way this therapeutic atmosphere is promoted is through the physical room itself and the rules for playing there. The play room in activity group therapy is characteristically abundantly filled with toys and games and the children are allowed to pick and choose freely among all of them. Very broad limits are set, and the children may mess up the room, break the toys, spill materials; but they will not be scolded for these activities. Any attempts to physically hurt oneself or others, or cause serious damage to the physical plant will be stopped, but other than these limits almost all other behavior is tolerated.

Thus the children can behave more freely than they are usually allowed to. This freedom facilitates catharsis which could not readily be accomplished within society's usual limits. The attitude of the therapist toward the children, and toward what they are allowed to do, usually promotes a very positive feeling toward the therapist from the children. Slavson has written that the unconditional acceptance of therapist comes to mean for the child that his therapist loves him totally. This, in turn, increases the child's positive feeling toward the therapist. Identification is thus fostered and the child cathects the therapist, becomes more like him or her, and is more willing to change for him or her. The environment plays a crucial role in determining the therapeutic relationship with the therapist. It theoretically decreases the amount of defensiveness of the children toward the therapist because the therapist is so accepting. Moreover, the therapist's interventions are usually attended

to significantly more because of the environment's rules and the therapist's behavior. In this context, in activity group therapy, a therapist might label the feelings the children are expressing, redirect their behavior toward more positive channels, give "explanations" of what the child is doing, and, in these ways, promote the child's gaining insight into his or her own state of mind or behavior, which strengthens the child's ego and strengthens his or her abilities to cope, function, tolerate and adapt more effectively.

For Relationship Group Therapy, some procedures are similar to that of activity group therapy and some different. Relationship Group Therapy is a short term approach and for this reason more action oriented. Directive forms of intervention are thought to be necessary to promote change in as short a period of time as ten to fourteen sessions. Relationship Group Therapy groups usually have practical considerations as well which necessitate different procedures. Relationship Group Therapy groups have been done in schools and in counseling centers where budgets are low and administrations cannot afford to allow children to break toys and destroy property. Moreover, Relationship Group Therapy goals are usually interpersonally oriented as well as intrapsychically oriented, while the Slavson groups focus primarily on the latter. Being able to make friends, work with peers, not be picked on, are all goals for at least some of the children in Relationship Group Therapy groups.

Relationship Group Therapy groups are similar to activity group therapies in that the therapist at least initially

(first four or five sessions in fourteen sessions group) attempts to be warm, tolerant, permissive, and caring, displaying unconditional positive regard. The limits imposed, however, are stricter. There are not an abundance of toys to pick and choose individually and freely from, but one project or game activity for the first thirty to forty minutes that all are encouraged to participate in. There are no other materials available other than the ones gotten for that particular time. This lessens the children's opportunities for catharsis, not seen as a curative factor in Relationship Group Therapy; but it increases group member interaction in obtaining group member's individual and interpersonal goals. Therapists decide before the group whether the first activity will be individually oriented (a project for each child to make) or interpersonally oriented (a group project or game) depending on what goals therapists think children need to work on. Even with individual projects, however, there will be an interpersonal component, e.g. material will be shared. It is theorized that the atmosphere and therapists behavior are still positive and permissive enough so that identification is promoted. As with activity group therapy, Relationship Group Therapy therapists, in promoting insight, will label the feelings the child is expressing, redirect their behavior, and give "explanations" in promoting insight. These are labelled indirect or non-intrusive interventions because they indirectly promote insight. Relationship Group Therapy therapists will also interpret a child's behavior, not done in activity group.

therapy. By interpretation is meant a statement by the therapist about something which the child is unaware. It is considered a more "direct" or "intrusive" form of intervention.

Because of its short term nature and interpersonal focus, the regulation of behavioral and social factors in Relationship Group Therapy groups is also given a great deal of emphasis. Redl, in working with children in camp situations, puts children in bunk groups with a therapist/counselor where most of their activities are interpersonally focused and the group is of primary importance. These procedures set the atmosphere for the regulations he theorizes as being of primary importance in the treatment of a child population, which, for the most part, had difficulty dealing with peers and authority figures. In Relationship Group Theory, by having the children interact with one another on one project or even sharing material when working on individual projects, a setting is promoted where children interact, display their strengths and difficulties, and create situations where therapists may intervene in facilitating positive change. The second thirty minutes of each Relationship Group Therapy group usually consists of an outside game with a group focus. The children then eat together and talk about the group or other materials important to the children. This is the last thirty minutes of the group's ninety minute session, and something borrowed from "the food table" used in Slavson's groups.

Relationship Group Therapy groups do not have all the time that Redl's groups have in developing the group

cohesiveness necessary to motivate children for behavioral and social regulations to be important and valuable to them. In Relationship Group Therapy groups, this is done by first promoting interaction, as discussed previously. As the children share their interests and concerns (also facilitated by the positive and accepting atmosphere), the therapists cite similarities and differences. Self disclosure by the therapist is also a powerful tool in building cohesiveness and empathy. The value of the "group" as seen in group decision making, eating together, functioning as a unit, is a social regulation which theoretically increases self and group pride while facilitating closeness, empathy, and the learning from each other. A group member's comment about another takes on more significant meaning because the children have formed relationships with each other and are part of a group. With cohesiveness and the therapeutic atmosphere described as a base, contingencies can be set up and children reinforced accordingly, cause and effect relationships explained, directing children through alternative methods of communication can be done, challenging, feedback, role playing, all can be used to change children's behavior while also changing feelings toward self. A great deal of insight and new methods of interacting are gained by the children during these procedures giving them the understanding of "what works" and what doesn't, and how they feel about things important to them. This insight and rewards from new productive methods learned (via regulation of behavioral and social traffic) gives them the tools to continue along.

these new found lines. The above methods used are labeled as direct/intrusive interventions.

The following section will specifically focus on the stages of therapy, and types of interventions designed in such a manner as to foster rapid, positive, lasting change.

II: Relationship Group Therapy

A. Stages and Methods

Through experience, we have found it therapeutically useful to conceive of the group going through three stages, introduction, middle, and termination. In short term work, introduction is usually three to five sessions, middle is five to seven sessions, and termination three to four sessions. Each stage signifies a different therapeutic approach, described in detail under the three headings that follow.

Stage I: Introduction and Preliminary Sessions. Relationship Group Therapy initial sessions usually follow the general therapeutic orientation of the Slavson groups which are understanding, permissiveness, and caring. Children are often surprised at these "new rules" which are appropriate for this setting.

The first project (second session) involved hammers. Steve started to bang his hammer against an old wooden desk. The hammer broke.

Lonnie: Look everybody, Steve broke the hammer.

Steve: (Looking very guilty, anticipating trouble)

The therapist picks up the hammer and says, "Oh, the hammer broke." He goes to a box of supplies, hands Steve

another, doesn't comment on the incident (Steve knows he "did wrong") and says, "Here, try this one. The nails are on the table."

During such an incident, there is almost always unexpected relief displayed by the children. While Relationship Group Therapy is by no means limitless, therapist attempt initially to be non-directive and non-intrusive, allowing children space, except for the structural limits imposed and discussed previously. Within four or five ninety minute weekly sessions children have usually "come out," i.e., displayed the kinds of behaviors which typically get them in trouble. At the end of this five session period it is theorized that, in most cases, due to the setting and orientation, relationships have been established between most members and one or both of the therapists. Therapists during these sessions reflect feeling, self disclose, label, clarify, encourage, and in general, try to communicate that they empathize with the children, again very much like the Slavson approach. These are non-intrusive, non-directive interventions. Small attempts will be made to begin to change communications, a testing of the readiness to change. All the while, an assessment of each child, their strengths and weaknesses is being made, and discussed privately by the therapists. The following is an example of an individual non-intrusive intervention that might occur in Stage I.

Child: I'm gonna kill him.
 Therapist: You sound angry.
 Child: I'm not angry.
 Therapist: You sound angry to me.

Indirect/non-intrusive group approaches often involve defusing aggression for the service of a larger group purpose or goal, or steering the group subtly into an area the therapists see as more therapeutically productive. For example:

Five of the seven children are sitting at the table ready to eat. The other two are fighting. The therapist approaches them and says, "Will you two help me with snack? One person can open the drinks and the other serve the cookies." The children oblige and the group has snack.

Therapists can also "use the group" as an indirect group method of control.

T: We need everybody at the table to start snack.
 A and B: Gee whiz, come on C and D, we want to eat.
 T: (Announces) We'll eat when all the group is together.
 A,B,E,F: (in chorus) We want snack.
 C and D: Okay, we're coming.

This first stage of preliminary understanding, using non-directive, non-intrusive intervention not just intrusively intervening to change behavior, is a crucial step. Without it, therapists would be pretty much like all the other important people in the childrens lives, simply wanting them to change. But an acceptance of their feelings, and the realities associated with their real pain, is invaluable in establishing a relationship of specialness, mutual caring, and trust. Without these relational essentials, the therapy would not be successful. Resistances (children protecting themselves from thoughts and feelings and actions they fear) would be too great.

Often during the initial sessions, therapists do have to intervene more intrusively, perhaps to break up a fight, or in enforcing the broad limits set. For example, no one touches

the food until meal time. Therapists carry such interventions through, tailoring them to the susceptibility that the children have in hearing the messages of the therapist. Providing, understanding and allowing, however, are the overriding elements in beginning to help the children get in touch with their feelings, positive and negative, that will be surfacing as a result of establishing such an atmosphere.

Initially many questions from the children arise about the therapy and the therapists which are usually answered. Therapists will often respond to the underlying message of such a communication.

Child: Do you do this with other kids?

T: Yes, I do...Why do you ask?

Child: Just wondering.

T: I thought you might be wondering about whether I care about you. I do see other children, but that doesn't mean that I don't care. I do care about you and you're special to me.

During the first session, therapists usually ask the children why they think they're here. Because they're "crazy," "stupid," "retarded," "troublemakers," "to learn" among others are usually shouted out.

Child: "Well, tell us."

T: Well first of all, no one here is crazy, retarded or stupid.

Child: My brother calls me retarded.

T: Well, I'm sure he's wrong. You wouldn't be here if you were. This is a group where we're going to be learning how to make friends, or get along, or learning how to work on your own...It's a group where people can come and learn how to feel better about themselves, how to like themselves more.

Of course, the exact words vary. But the focus of the communications are very similar. Particularly with our short term therapies (10-14 sessions), a supportiveness and glossing

over with regard to some material, like "Are we retarded?" is usually done. With longer term therapies (30-40 sessions), still short by some standards, it is more likely that therapists might explore the material in an attempt to work through these issues with the children.

Stage II: The Middle Sessions. At this point, most of the children, in varying degrees, have "come out." They feel the opportunity to express themselves and these feelings surface and get smothered, by the child him or herself, or by other children; or sometimes they surface and are felt and carried out by the children. Therapists attempt to point out when these happen and in Stage II they often intervene intrusively when a child attempts to prevent another child from expressing him or herself in a positive way. The tendencies to actualize appear but are often blocked severely in many ways, due to previous pain and present fear. The therapist's job is to help the children overcome their blockings and realize and experience their potentialities. This can be done directly and intrusively, theoretically because basic relationships have already been established via Stage I.

The interventions in Stage II can best be seen on a two-dimensional axis: indirect-non-intrusive/direct-intrusive, and individual/group. These are also moderated by three variables:

1. Receptivity of the child, problem by problem.
2. The point of therapy (beginning or end of the therapy, or of a session).
3. The overall context.

Stage I usually involves mostly non-intrusive individual and group interventions, the Slavson approach. With some

children even in Stage I, direct approaches are used and these can serve as a model; however, indirect non-intrusive approaches early on is most usual. As the children's receptivity to therapists' communications increases, Relationship Group Therapy therapists can usually become more intrusive or directive, more in line with the methods of Redl. These interventions include interpretation, challenging, contracting, pointing out reality and giving feedback. Using the same example of "I'm gonna kill him," the following is an example of a direct/intrusive individual intervention, which is more likely to be seen in Stage II.

- C: I'm gonna kill him.
 T: You sound angry.
 C: I'm not angry.
 T: You're clenching your fists, your voice is raised, your face is red...Why are you angry at him?
 C: Cause he's a stupid turkey.
 T: What did he do to you?
 C: He got glue on my flag.
 T: He got glue on your flag. That hurt you and now you're angry at him.

The former example of a non-intrusive individual intervention is more like Slavson, the above example more direct and confronting like Redl. If the relationship with the child is such that he or she will stay involved even if the therapist is directive, the directiveness is most appropriate. If the problem is such that the child can "hear you," the therapist can be more directive. In general, however, serious problems should not be dealt with in a direct/intrusive manner when there's not enough time left in the session, or at the first stage of therapy. We assume that direct/intrusive methods produce change (positive or negative) at a faster

rate and cannot be easily ignored by the children. Therefore these methods must be done properly by the therapist. They are more powerful because they require an immediate dealing with a demand to see and act upon a situation differently. When a therapist sees a child blocking out, i.e. "not hearing," the therapist goes back to non-intrusive, indirect methods which will often re-establish positive contact with the child. Then one can again be more directive. Therapists attempt to find the appropriate balance, always taking into account the relationship with the child and the nature of the problem.

Intrusive/directive group approaches are also used in Stage II. The following is an example, the goal of which was to facilitate the communications of two fighting children.

T: (physically separating the children)
 What happened? You both look really angry
 (labeling the feeling) at each other.
 Dave: He took my hat.
 Tommy: I did not. (leaps toward Dave, therapist
 separates them)
 T: (to Tommy) Tell him why you're angry at him.
 Tommy: I'll show him.
 T: No. Showing him gets you in trouble.
 There are other ways of getting him to
 understand your feelings. Do it with words.
 Tommy: I hate him.
 T: Tell him why.
 Tommy: Cause he walks funny and he's ugly.
 T: But why are you angry at him? What did he do
 to you?
 Tommy: He's always buttin' in, grabbing the
 ball when Steve and I are playing.
 T: You're angry with him for butting in with
 you and Steve. What else?
 Tommy: He always grabs all the food for himself.
 T: Tell him.
 Tommy: You always grab all the food for yourself.
 T: What should he do so that you wouldn't get
 angry at him?
 Tommy: (simmering down) Well, not grab the food
 all the time, and not butt in to the ball game.
 T: What should he do if he wants to play?
 Tommy: Ask.
 T: Will you let him play?

Tommy: Maybe.

T: Okay, Dave. That's important information for you to have about how to get into a game and about what you do that gets people angry. Dave, why are you angry at Tommy...

And the same is done with Dave. These interchanges are often very intense and very fast. The labeling of feelings is often a preliminary step in direct/intrusive interventions. Then, through directing the children through alternative modes of communication, giving information, planning alternatives, and being quite intrusive and demanding, learning how to get along is being accomplished. After doing this two or three times, the children learn to "tell him/her how I feel" and learn new methods for handling interpersonal conflicts.

Direct/intrusive interventions often are used in combination with indirect methods.

C: I can't do it.

T: I know it's hard, you're frustrated, but, stick with it.

C: I can't do it.

T: No, that's in your head. I know you and I know you can do it. Now come on and I'll be here, and I'll help you. But you must try.

The demand and the challenge are both being used here as is the labeling of feeling and encouragement. The relationship is also being used, and there must be a strong relationship to be successful with such a directive intrusive approach. But if the child does it, the therapist can point it out, ask the child how he/she feels, and either deal with those responses or move on. One almost never does the necessary task for the child. They must know that it came from them. But being supportive is usually appropriate.

During Stage II, therapists attempt to be more "real." This means that they can express their anger, their joy, their feelings and their thoughts in a more open, direct, and honest fashion. They need not always be supportive and display acceptance and positive regard. From a planned positive relationship, in Stage I, a truer one is attempted in Stage II. It is theorized that children at Stage II can deal with negative feelings from the therapist, while understanding that it doesn't affect their basic ties. This kind of feedback is often very useful information for children. Again, this points to the importance of Stage I. During Stage II, a therapist might say, "I'm really mad at you" and tell the child specifically why. That now has meaning because there is a relationship context present. To say this early, i.e., in Stage I, the child might answer, "Who cares;" and probably mean it. The realness and authenticity of the therapists in Stage II contribute positively to the realness, authenticity and meaningfulness of the group for the children, while being less threatening because of Stage I processes. It contributes positively toward meaningful change by more closely resembling relationships in the real world. It also enables children to identify with someone displaying a wide range of emotive, logical, and coping behaviors. The fallibility of the therapist at Stage II is something children can also deal with and is an important reality factor in the relationship.

Indirect methods are never abandoned however. Direct methods rest on indirect methods, and involve indirect methods. Therapists get more directive when they believe such interventions

will produce positive change. This usually occurs when the relationship is established, when children are receptive, and when the context complements the intervention. When therapists in Stage II "move in" openly and directly, it doesn't have to be by implication, or gently, but can be, in some instances, rough, direct, and to the point.

At times, strong resistances by children or the desire for "quick cures" by therapists lure therapists toward direct methods prematurely. These interventions, however, must be preceded by the formation of a relationship. This involves minimal degrees of perceived trust, understanding, and caring by the child, or by the children. It's hard to recover from a mistake of this sort. One must first prove that he or she will "be there for" the child, when the therapists may have already not done that in the eyes of the child.

Stage II is a time when work is being done on intrapersonal and interpersonal levels. Group and individual, non-intrusive-indirect and intrusive-direct methods are used. Because of Stage I processes, the children identify with the therapist and begin to change in a positive way and this continues throughout therapy. By the use of intrusive/non-intrusive, and group and individual methods, insight is gained. Specifically by the use of our intrusive methods, the regulation of behavioral and social traffic, the children's behaviors change, as does their attitudes and approaches toward themselves and their worlds. These processes are interactive ones and it is theorized that when used in combination, in the specified format and sequences being discussed, they provide the most effective short term treatment.

Stage III: Termination. At the end of Relationship Group Therapy, following the treatment procedures of Stage I and II, it is hoped that children have improved in different goal areas according to themselves and significant others in their lives. One thing is almost always clear. Relationships have been formed and are not easily let go. This goes both for therapists and for the children.

For one of the usually three termination sessions (in short term work), the children are taken on a trip. Therapists have gradually built up to it and now therapists and children meet the world together in a different setting from that of the therapy room. The sense of independence while sharing a unique experience together helps to further transfer the therapeutic learning to the real world by seeing therapists more like other people in the world the children come in contact with. Plus, it helps Relationship Group Therapy end on a happy note.

Therapists usually tell the children about three sessions in advance that the therapy is ending. The children usually have had a vague idea, but weren't really sure about how many sessions remained. This announcement is always followed by some type of symbolic activity on the part of the children representing their feelings. Children are concerned about being left alone, and about losing support systems which have been formed. Many children fear the positive changes will disappear. Often children feel termination means the therapists are not fond of them anymore. Therapists during these sessions are continually aware that these behaviors, at least

in part, are due to termination, and intervene with the children with this in mind.

It is a difficult time. It is a time when therapists find out again that what they have said to the children is correct. They almost always do care about the children; they are special and can't just be replaced by another group of kids. There have been groups in the past when children have helped therapists with their own feelings of group loss.

Relationship Group Therapy therapists must be quick to understand and react to the termination issues the children have. Termination is a time where therapists are citing growth and strength, and new approaches learned, and support is given to all. Direct/intrusive methods of intervention lessen. The group members are encouraged to support one another, and the therapists help to maintain that positive track. Support, encouragement, labeling of feelings, self disclosure, indirect/non-intrusive interventions are once again the primary therapeutic interventions.

Children in Relationship Group Therapy groups have, in the past, reacted to termination in a variety of ways. They have denied termination entirely. They have screamed in anger, symbolic and otherwise. Children have sung songs spontaneously, whose message has been, "We love you." It's very often a time for presents, a time for nostalgia, a time of sorrow, and a time not soon forgotten by anyone.

With short term groups of eight children, ten to fourteen sessions, therapists may see half the group one week, half the next, and then all come together for the final session. This

has occurred when therapists have felt the need for closer contact with the children to emphasize particular points about their growth, and this method has been the vehicle for that. Therapists also talk about how others can like them, as the therapists have, and how other adults can also help them when they need help. What other goals the children need to work toward is also discussed during these times.

B. The Therapists

There are many qualities and attributes Relationship Group Therapy therapists must possess regarding their interactions with the children and with each other.

With the children, Relationship Group Therapy therapists should present themselves as an ally. They are motivated to help but yet not in a missionary zealous kind of fashion. They need to be unusually sensitive, both with regards to children's feelings, their own feelings, and in understanding the latent, symbolic communications of the children they are working with. Relationship Group Therapy therapists need strong personalities but with a gentle way about them. They must be able to take care of themselves. At times, they must "see without looking," i.e. not intervene on all negative behaviors. They must verbalize on the level of the children with whom they're dealing. The child in them, curiosity, imagination, enthusiasm, spontaneity should be present and obvious to all. They need to know their feelings most of the time, and also be able to disclose them honestly. They need to be flexible and have basic craft and project skills. They also need lots of energy.

The relationships formed in Relationship Group Therapy groups are the essential ingredients for curative factors to occur and be effective. Establishing a consistent emotional relationship with each and every child is necessary for growth to occur. In establishing such a relationship, or working through problems associated with forming relationships, much of the maladaptive communications, the closedness of many children, the lack of risk taking, and the misperceptions about self and relationships can be changed. The relationship can also be used in helping, sometimes pushing, children toward facing themselves, or another, or an object. It is through those relationships where modes opposed to these are dealt with, or broken, and hopefully the benefits of insight, identification, and behavior change are enjoyed.

Therapists must pay close attention to each individual relationship formed. They need to be aware of cultural and socioeconomic backgrounds, and be sensitive to these. (For example, a lower class child will fight to keep new sneakers clean. A middle class ritual is often to stamp on new sneakers until they're dirty.) They need to watch out for feelings about the children, both positive and negative, that involve more of the therapist's past, than present relationships with the children. Therapists have often found that children's behavior is maintained by important others enjoying their pathology, or the surrounding "cute" behaviors, or enjoying a child's clear, longing, pained messages. Therapists in Relationship Group Therapy help each other deal with such issues, for often therapists will not be aware of how they

might be maintaining a child's negative behavior in group. This is another advantage of employing two rather than one therapist per group.

Male and female therapists are nearly always present in Relationship Group Therapy groups. They symbolize the ideal parents which increases identification processes while increasing the sense of family in the group. The therapists show children that there are adults different than their parents who offer alternative views of the child's experience. They show that there are others that children can care about, and identify with, who can help with the possibilities of how to respond to themselves and to their worlds. The female therapists perform the same therapeutic functions as the male therapists with differences. Unique male and female issues, e.g., a male child dependent on adult females or a female child distrustful and fearful of adult males, are handled by the appropriate gendered therapist, at times in collaboration with the other therapist and/or with other children. Those issues are dealt with as the relationships are being formed.

The idea of male and female therapists are a unique, valuable contribution to child group therapy theory. Issues of gender can be dealt with more accurately and appropriately. Also, the male/female adult relationship can serve as a continuing model of a warm, giving relationship where two people disagree, agree, and yet are pleased with each other and with themselves. Both therapists form a subsystem which is often necessary in avoiding becoming overwhelmed by the children and their difficulties. Each therapist serves as an anchor to the other.

For a therapeutic relationship to occur, both therapists should be able to handle adult male/female relationships well. They each need a basic understanding of each other and their goals for themselves and the group. A meaningful dialogue of wishes, concerns, giving and taking, should be ever present. It should be an ongoing relationship in the sense that it continuously changes. They can be close friends but a romantic relationship is advised against because of its complexities, and the loss of a detached observational perspective by both members for each other. They should, however, feel and show support and care for each other, stick up for each other ("You can't insult my co-worker, he/she is a person and my friend."), joke with, and root for each other and do all the things that speak of co-working relationships. It must always be remembered that the children will most often strongly identify with the therapists and the values they espouse and act upon.

C. Values

What are the values of Relationship Group Therapy? The following is a list of these major assumptions. Peaceful solutions are usually better than violent ones. Feelings are very important and people should be aware of what they feel for feelings effect behavior. People can also learn how to behave in a different manner which will change how they feel. People in general, should learn to be more accepting of others. People relationships are the most important relationships. People have a growth potential and strive toward actualization, and this process is the primary motivational process.

Therapy should always have a component of evaluation.

From these values come many of the nuances of Relationship Group Therapy interventions. During Stage II, for example, children are taught contracting, a non-violent approach as a way of resolving differences. They are encouraged to try out new behaviors. Also, therapists often state positive, accepting perspectives representing an optimistic growth oriented humanistic view, for example.

Kenny: I'm bad. You should only know all the rotten things I've done.

Therapist: I've done a lot of rotten things myself. It doesn't mean I'm a bad person, just that I've done bad things. And we can change.

If a child hits a therapist in group, the therapist might say "People are not for hurting" emphasizing again the non-violent perspective. The therapist might also say "It hurts me. I like you less when you do it. It makes me angry at you," stressing the importance of the human relationship in that interaction along with the moral or societal value of "people are not for hurting."

While there are many values espoused and upon which our methods rest, these are the more basic prominent values which rise repeatedly when discussing and reflecting upon Relationship Group Therapy.

D. Evaluation

Not only have the major child group theoreticians not adequately evaluated their respective approaches, but this is an overall criticism of the child group area (Abromowitz, 1976).

terms of both process and outcome measures. The present study focuses on outcome, but monitors the process.

Concerning process as has been discussed previously, there are certain structural elements described in Relationship Group Therapy groups. Male and female therapists are present, there is an initial game or project, followed by snack and discussion. By use of the Relationship Group Therapy Process Checklist (See Appendix A), these will be checked by each therapist as to whether these did or did not occur.

As Relationship Group Therapy develops through it's described stages, the focus shifts from primarily non-directive/non-intrusive, to a combination of the latter with directive/intrusive interventions, to the final stage where the focus is again on non-directive/non-intrusive interventions. Because of the structural impositions of Relationship Group Therapy, however, all forms of intervention are purported to be used in every session. Thus the **process check list** contains questions for the therapists as to **whether they used each kind** of intervention and procedure for each session.

The outcome procedures, methods, and measures will be discussed in detail in the following sections. Relationship Group Therapy is a relationship oriented therapy and thus the outcome measures are designed and tailored specifically toward assessing differences in the children's relationships over specifically designed periods of time. The major relationships in a child's life involves his/her relationships with other children, with authorities, within his/her family,

and within him/herself, and these are the specific groupings under which each rater will assess improvement or lack of it.

Evaluating the Effectiveness of Relationship Group

Therapy in an Elementary School Setting. In evaluating the effectiveness of Relationship Group Therapy in an elementary school setting, thirty-two 8-12 year old children were deemed in need of treatment in the beginning of the school year. All children, their teachers, parents, and therapists (for those to be in the group in the fall) filled out a measure for goals to be attained by the children (Goal Attainment Scales, Kiresuk & Sherman, 1968). Children filled out a measure assessing their locus of control (Nowicki-Strickland Locus of Control Scale, 1973). Half the children were randomly designated to be in treatment in the fall for fourteen sessions. At the end of this time, all completed Goal Attainment Scales, and new ones were filled out for goals to be attained in the spring. Children were again given the locus of control measure. The sixteen not in treatment in the fall were then given treatment for fourteen sessions, the other sixteen children serving as a five month follow-up group. At the end of this period, all Goal Attainment Scales were completed and children again given the locus of control measure.

Results show that both treatment groups attained significantly higher goal attainment scores, versus control, for each of the four raters. Follow-up group goal attainment scores did not significantly differ from treatment scores. Scores on locus of control did not predict goal attainment but children did become more internal by the conclusion of treatment, but the change seems to be a transient one.

APPENDIX A

RAG Check List

Group _____ Date _____

Setting _____

Therapist _____

Session number _____

	(Yes)	(No)
There was time for a structure game or project.	_____	_____
There was outside group time, or a physical game was played.	_____	_____
Snack was served.	_____	_____
There was a discussion time.	_____	_____
Male and female therapists were present.	_____	_____
Were indirect methods of control used (e.g., asking two fighting children to help you move a table)?	_____	_____
Were direct methods of control used?	_____	_____
Did children get help with projects?	_____	_____
Did you give explanations?	_____	_____
Did you reflect feeling?	_____	_____
Did you use interpretation?	_____	_____
Was catharsis possible in the group?	_____	_____
Were you a source of information?	_____	_____
Was it set up so children could talk to one another?	_____	_____
Was it set up so children could talk directly to the therapist?	_____	_____
Was play organized?	_____	_____
Were you direct and confronting?	_____	_____
Was the here and now the main focus?	_____	_____
Did you feel there was a give and take?	_____	_____
Were you very active at some point in the group today while other times passive?	_____	_____
Did you present alternative ways of doing things to the kids?	_____	_____
Were you both permissive and stern?	_____	_____

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